MARYLAND HEALTH QUALITY AND COST COUNCIL

Meeting Minutes
December 9, 2012

Members in Attendance: Secretary Joshua Sharfstein (Vice Chair), James Chesley, Lisa Cooper, Richard "Chip" Davis, Barbara Epke, Roger Merill, Peggy O'Kane, Marcos Pesquera, Albert Reece, Jon Shematek, Kathleen White, and Christine Wray

Members Absent: Lieutenant Governor Anthony Brown (Chair), Jill Berger

Staff: Laura Herrera, Carlessia Hussein, Katie Jones, and Russ Montgomery

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Welcome and Approval of Minutes
Secretary Sharfstein called the meeting to order at 9:32am. He welcomed the Council members and guests to the meeting and announced that the Lieutenant Governor was unable to attend. Minutes from the September 14, 2012 Council meeting were approved.

Wellness and Prevention Workgroup – *Christine Wray*
Christine Wray, chair of the Wellness and Prevention Workgroup, presented an update on the workgroup's initiatives. Staff members continue to hold Healthiest Maryland Businesses (HMB) regional forums across Maryland. They have also developed new web-based resources that highlight DHMH programs in heart disease and stroke, including Million Hearts, diabetes prevention and control, and tobacco cessation. A statewide tobacco cessation webinar was planned for December 20, 2102, and new programs exist for youth and pregnant women. They have also implemented Text2Quit®, which provides text message support for quit attempts, and Web Coach®, a web-based counseling program available at www.quitnow.net/maryland. In addition, to highlight promising efforts across Maryland, they have launched HMB Success Stories. Four companies' stories – Mertitus Health, McCormick and Company, Lifbridge Health, and Marriott – will be published by the end of the year, with stories from Perdue Farms and MedStar Health coming in January.

Ms. Wray also provided an update on the Community Transformation Grant (CTG). Activities this quarter included four regional tobacco-free living meetings and dissemination efforts through presentations to key groups of stakeholders. Recent accomplishments include implementation of smoke-free practices in two county governments and discussion of CTG efforts at the American Public Health Association annual meeting.

Within the past quarter, there have been significant Million Hearts activities, as well. In Anne Arundel County, an obesity prevention program was implemented in public schools. In Baltimore County, training was provided to local health department and social service staff on smoking prevention and cessation. In Montgomery County, efforts are underway to implement strategies to optimize the use of community health workers (CHWs) for addressing the ABCS in low income uninsured minority adults. Additional efforts to utilize CHWs are underway in Prince George's County and Baltimore City.

Ms. Wray then discussed Million Hearts national goals for 2017 and outlined Maryland's plan to meet the targets. Strategy 1 is to improve clinical care, strategies 2 and 3 are to reduce smoking and promote health diets and physical activity, and strategy 4 is to encourage workplace wellness. Staff are developing partnerships with University of Maryland, MedChi, Lifebridge Health, and others on these strategies. Strategy 5 is to incentivize public health action. Efforts include Million Hearts webinars and a social media campaign for Million Hearts through the Maryland Transit Administration in January 2013.

Next steps for the Wellness and Prevention Workgroup include planning a statewide Million Hearts event to be held on February 13, 2013 and promotion of the Million Hearts website.

Roger Merill commented on how helpful he found the HMB regional event he attended. He was impressed by the turnout. Secretary Sharfstein thanked Ms. Wray and the workgroup staff for their ongoing efforts.

Cultural Competency Workgroup – *Lisa Cooper and Marcos Pesquera*

Co-chairs Lisa Cooper and Marcos Pesquera presented an update on the Workgroup's activities over the last quarter. The Maryland Health Improvement and Disparities Reduction Act, signed into law by Governor O'Malley in April 2012, established the Cultural Competency Workgroup. A total of 49 individuals were appointed by Secretary Sharfstein to serve on the Workgroup from 70 nominations. A few Council members voiced concern that this may be too many members for the Workgroup to be productive. Dr. Cooper and Mr. Pesquera noted that they were cognizant of that issue and will organize the members into subgroups to take on specific tasks:

(1) Examine appropriate standards for cultural and linguistic competency for medical and behavioral health treatment and the feasibility and desirability of incorporating these standards into reporting by health care providers and tiering of reimbursement rates by payors;
(2) Assess the feasibility of and develop recommendations for criteria and standards establishing multicultural health care equity and assessment programs for the Maryland Patient Centered Medical Home program and other health care settings; and

(3) Recommend criteria for health care providers in Maryland to receive continuing education in multicultural health care, including cultural competency and health literacy training.

The first meeting of the workgroup was held on November 29. The co-chairs discussed the charge of the workgroup and a draft work plan. Members were asked to submit ideas and activities in which they are interested. The next meeting is planned for January 2013.

Maryland's Multi-Payer Patient Centered Medical Home Program – *Ben Steffen, Maryland Health Care Commission*

Ben Steffen, Executive Director of the Maryland Health Care Commission, updated the Council on the Maryland Multi-Payer Patient Centered Medical Home (MMPP) program. He began be noting that the MMPP was borne out of discussions by the Council. The program was created by an administration-sponsored bill in 2010. Fifty-three pilot sites began in May 2011, including family practices, federally-qualified health centers, and other providers. In total, 330 physicians and nurses and 250,000 patients are part of the program.

The Maryland Learning Collaborative (MLC) is leading efforts on practice transformation. Fixed transformation payments to practices totaled $9.4 million. Fifty-two practices have achieved NCQA recognition, and most have reached level II or III. Four large collaborative meetings have been held to date.

All practices must use an electronic health record (EHR) and submit quality data, which align with CMS meaningful use criteria. There are six measures for pediatric practices, 18 for adult, and 21 for practices with both populations.

The MMPP has its own shared savings methodology. It was tested using 2009-2010 data and confirmed with input from payers. To calculate payments, the MMPP utilized the Maryland All Payer Claims Database. The initial calculation revealed significant random variation, leading to refinements of the methodology. They established a 10 percent payment performance limit, which reduced shared savings payments from $1.2 million to $0.8 million.

Impaq International is completing an evaluation of the program. The three main approaches are to assess (1) cost and quality, (2) patient satisfaction, and (3) provider satisfaction. The patient and provider surveys will be in the field in early 2013.

In 2013, the MMPP program will expand sharing of carriers' claims data with practices, with the goal of creating a common data interface. They also plan to encourage practices to participate in the state health information exchange. They will = implement stage 2 of shared savings, which requires practices to meet quality thresholds.

Community Health Center Criteria – *Karen Matsuoka, DHMH*

Secretary Sharfstein introduced Karen Matsuoka, PhD, as the Director of the newly-created Health Systems and Infrastructure Administration (HSIA) at DHMH. HSIA was created through a reorganization of the public health unit of the Department and will play a critical role in planning for health care delivery system changes that will occur as part of larger health reform efforts. Dr. Matsuoka was most recently employed at the Brookings Institution, where she led Brookings' work on state health reform issues. She also previously worked for the Office of Management and Budget in the federal government.

Dr. Matsuoka began her presentation by providing a high-level overview of the coverage expansions under the Affordable Care Act (ACA). Nearly 200,000 Marylanders will gain Medicaid coverage as part of the ACA, while 285,000 will gain private coverage. Maryland has 16 federally-qualified health centers (FQHCs), 24 local health departments, and 30 plus free clinics and school-based health centers. She noted, however, that coverage is not tantamount to access, and these newly-insured individuals will put strain on the capacity health care system. The roles of safety net providers must evolve as more Marylanders move into health coverage.

Given these changes, DHMH has proposed a voluntary certification program that will help assess safety net provider readiness along a variety of dimensions that will be increasingly important with health reform, such as financial stability, accessibility to the community, the ability to demonstrate the provision of high quality care, and engagement in local public health partnerships. The goal of this program would be to identify willing participants and to use the assessment results to identify appropriate programmatic, funding, and technical assistance opportunities.

A public comment period was held to allow for feedback on the criteria. To date, they have received 14 letters or emails from 29 organizations and individuals. Following this comment period ending January 12, 2013, DHMH will review the comments and determine whether to propose regulations for implementation.

Secretary Sharfstein thanked Dr. Matsuoka for her presentation.

Maryland Health Quality Portal – *Russ Montgomery, DHMH*

Russ Montgomery, staff director of the Council, introduced the Council to the Maryland Health Quality Portal (http://dhmh.maryland.gov/quality), a new website produced by DHMH that is intended to serve as a "one stop shop" for health care quality information. The portal contains links to quality information on hospitals, long-term care, health plans, and physicians. Most of the links direct users to information produced by the Maryland

Health Care Commission and the Health Services Cost Review Commission. Other links direct users to external quality sites. He asked the Council members to send him any suggestions they have for additional resources to include on the portal.

2012 Annual Report – *Russ Montgomery, DHMH*
Mr. Montgomery introduced a draft of the 2012 Annual Report from the Council. This annual report is mandated in the executive order that created the Council and contains an overview of the Council and its workgroups over the past year. Secretary Sharfstein stated that any suggestions for revisions should be submitted within one week. At that point, the report will be considered approved.

Evidence-Based Medicine Workgroup: Value-Based Insurance Design

Secretary Sharfstein stated that value-based insurance design (VBID) is a natural next step following previous discussions of consumer-driven health plans. VBID provides an opportunity to not only lower costs for patients, but has also been shown to improve quality and outcomes. He invited Anne Timmons, who leads the Maryland state employee health plans, and Glenn Schneider, a member of the Maryland Health Care Commission, to join the discussion. Ms. Timmons briefly overviewed the state employee plans and the number of lives covered under the plans.

Secretary Sharfstein then introduced Peggy O'Kane as the new chair of the Evidence-Based Medicine workgroup. She has been a proponent of VBID in previous Council meetings, and her expertise will help guide our work in this area. Ms. O'Kane said she was happy to serve, and feels that VBID is an area in which Maryland can really be a leader among states.

Mark Fendrick and Katy Spangler, University of Michigan and VBID Health

Secretary Sharfstein then introduced Mark Fendrick and Katy Spangler from the University of Michigan and VBID Health. Dr. Fendrick and colleagues developed and named the concept of VBID. He is a professor of internal medicine and health management and policy at the University of Michigan. He is co-director of the Center for Value-Based Insurance Design at the university and a partner at VBID Health. Dr. Fendrick received his medical degree from Harvard Medical School. Katy Spangler is also a founding partner at VBID Health. Ms. Spangler was previously Deputy Health Policy Director of the United States Senate Health, Education, Labor, and Pensions (HELP) Committee, where she played a key role in developing the Affordable Care Act. She also previously worked in the Office of the National Coordinator for Health Information Technology at HHS. Dr. Fendrick presented to the Council via teleconference, and Ms. Spangler joined in-person.

Dr. Fendrick began the presentation by noting that cost growth remains the principle focus of health care reform discussions. Despite unequivocal evidence of clinical benefit, substantial underutilization of high-value services persists across the spectrum of clinical

care. Thus, it is important to shift the focus from how *much* to how *well* we spend on health care to maximize the amount of health produced for the expenditures made.

There are a range of interventions to control costs, and many of them have been used for years. These include prior authorization, disease management, information technology, prevention activities, and payment reform initiatives such as bundled payments, accountable care organizations and medical homes.

High deductible health plans, which increase cost-sharing, are another method. However, Dr. Fendrick stated that the archaic "one-size-fits-all" approach and lack of "clinical nuance" in patient cost sharing fails to acknowledge the differences in clinical value among medical interventions. Ideally, patient copayments would be used to discourage the use of low-value care. Increased patient cost-sharing without considering the effectiveness of services may lead to decreases in non-essential and essential care which, in some cases, lead to greater overall costs. He mentioned an instance in which copays for drug classes were doubled, which resulted in 19.8 fewer annual outpatient visits per 100 enrollees and 2.2 additional hospital admissions per 100 enrollees. Effects were worse in those with low income and patients with chronic illness.

Dr. Fendrick emphasized the importance of "clinical nuance" when reallocating medical spending. The clinical benefit derived from a specific service depends on the patient using it. The VBID premise is that the more clinically beneficial the service, the lower the patient's cost share and the higher the payment for a given service. An opportunity exists for a cost-saving reallocation within any health budget, through increasing use of high-value interventions and reducing the use of interventions that offer little or no benefit.

A broad definition of VBID was included in the ACA: "Value-based insurance designs include the provision of information and incentives for consumers that promote access to and use of higher value providers, treatments, and services." The ACA also contained provisions that eliminated cost sharing for preventive services receiving an "A" or "B" rating from the United States Preventive Services Taskforce, as well as for some immunizations and screenings.

To date, most V-BID programs have focused on removing barriers to high-value services. VBID programs that discourage use of low-value services are increasingly being implemented. One example is the Choosing Wisely program.

A substantial majority of private sector VBID programs include reduced cost-sharing for evidence-based services for established diseases. These include medications and eye exams for diabetes, behavioral therapy and medications for depression, long-acting inhalers, and spirometers for asthma. VBID has perhaps the most power when it is aligned with other reform initiatives, such as wellness programs, disease management, comparative effectiveness research, health IT, and payment reform.

Blue Shield of California has implemented "Blue Groove," which combines wellness programs, advanced member engagement, value-based insurance design, and high-performing providers. Members qualify for lower co-payments only if they have one or more conditions and use a high-value provider. The program aligns clinical goals of supply-side (ACOs) and demand-side (VBID) initiatives.

Two state employees benefit plans have implementing major VBID initiatives: Connecticut and Oregon. Two states reference VBID in their health insurance exchange legislation: Maryland and California. Maryland's inclusion of this language provides an opening for a major VBID effort.

Dr. Fendrick finished by highlighting the Connecticut state employee program. Participating employees receive a reprieve from higher premiums if they commit to yearly physicals, age-appropriate screenings/preventive care, and two free dental cleanings. Employees must participate in disease management programs (which include free office visits and lower drug co-pays) if they have one of five chronic conditions. Ninety-eight percent of employees actively moved into the VBID plan over one week open enrollment. Currently, they are working on a strategy for adjusting copays to encourage participation in medical homes.

Roger Merrill noted that Purdue has value-based designs in their employee plans. Once employees understand how the program works, they are usually ready to participate. They have seen improved outcomes. He is very supportive of Maryland moving in this direction.

Joan Kapowich, Oregon Public Employees' and Oregon Educators Benefit Boards

Secretary Sharfstein thanked Dr. Fendrick for his participation, and then introduced Joan Kapowich, who leads the state employee health plans in Oregon and has been instrumental in carrying out their VBID initiative. Previously, she was the Medical Services Director at SAIF Corp and managed the Oregon Health Plan's Program and Policy Section. Joan's career includes over 25 years in health care delivery and quality improvement initiatives. Ms. Kapowich has a sociology degree from UC Santa Barbara, a nursing degree and has completed graduate coursework in health statistics and management. Ms. Kapowich presented to the Council via teleconference.

Ms. Kapowich began by noting that two boards dictate the operation of their state employee plans. These boards are required by statute to seek health plans that offer "creativity and innovation, improvement in employee health, plan performance and information, affordable care, and flexibility in benefit design." Previous efforts related to health and wellness included free flu shots, free health screenings, walking programs, and similar programs.

More recently, the boards decided to promote improved health outcomes through changes to benefit design. Initially they reduced copays for 17 services (this was pre-ACA):

- Free tobacco cessation – no or low cost medications
- Free weight management (participation requirement)
- Free value medications – chronic conditions, cardiac, high blood pressure, diabetes and asthma
- No or low cost office visits for chronic conditions

Within their benefits package, they offer different tiers of services. This was initially based on Oregon's well-known prioritized list of services. Services are now placed into these tiers based on evaluations of value. The low value, top cost tier increases copays for the following services:

- $500 co-payment not subject to the deductible & out of pocket maximum
- Spine surgery, hip & knee replacements, shoulder and knee arthroscopy, bariatric surgery, sinus surgery
- $100 for sleep studies, spinal injections, CT,MRI, SPECT imaging, upper endoscopy, ED visits

While a comprehensive evaluation is currently being conducted, some interim outcomes are available. Utilization has decreased between 15 and 30 percent for the services in the low-value tier. Tobacco use fell from 12.4 percent in 2007 to 5.8 percent in 2012. Participation in weight management programs has been about 14 percent, and obesity rates for employees fell from 28% to 23% over the same period. Given these results, they estimate a $2 million return on investment from just one year of covering weight management services at no cost. In addition, nearly all HEDIS measures are in the 90th percentile.

Ms. Kapowich also addressed barriers they had to overcome in implementing this program. Carriers attended all meetings about the benefit design, and her staff developed a positive relationship. Implementation was not easy, but was doable once everyone was involved in discussion. In was especially important to focus on member understanding and links to support materials.

They are planning to implement additional value-based benefits in 2013. These include in-network substance abuse treatment and expansion of free or low-cost drug benefit to include additional generics for hypertension and depression. In addition, beneficiaries with a primary care provider that is certified as a patient-centered medical home will receive a drop in cost-sharing from 15 percent to 10 percent (outside of the low-value tier). They are also researching options for a physical activity benefit and additional services to consider for the low-value, high cost-sharing tier.

Adjournment

The meeting was adjourned at 11:50am. Secretary Sharfstein noted that dates for 2013 meetings will be announced soon.